COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, JUNE 7, 2002

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

CASE NO. INS-2002-00060

Ex Parte: In the matter of
Adopting Revisions to the Rules
Governing the Implementation of
the Individual Accident and
Sickness Insurance Minimum
Standards Act

ORDER ADOPTING REVISIONS TO RULES

WHEREAS, by order entered herein April 29, 2002, all interested persons were ordered to take notice that the Commission would consider the entry of an order subsequent to May 30, 2002, adopting revisions proposed by Stephen D. Rosenthal, Esquire, to the Commission's Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act to define and clarify what is necessary for coverage to be considered "limited benefit health insurance coverage" and to make non-substantive revisions to certain language in the Rules, unless on or before May 30, 2002, any

Effective April 9, 2002, the new Case Management System requires that the case number format for all Commission orders change from, e.g., PUE010663 to the following: PUE-2001-00663.

person objecting to the adoption of the proposed revisions filed a request for a hearing with the Clerk of the Commission;

WHEREAS, the April 29, 2002, Order also required all interested persons to file their comments in support of or in opposition to the proposed revisions on or before May 30, 2002;

WHEREAS, as of the date of this Order, no request for a hearing has been filed with the Clerk of the Commission;

WHEREAS, as of the date of this Order, no comments have been filed with the Clerk of the Commission;

WHEREAS, the Bureau has no objection to the proposed revisions; and

THE COMMISSION, having considered the proposed revisions and the Bureau's position, is of the opinion that the attached proposed revisions should be adopted;

THEREFORE, IT IS ORDERED THAT:

(1) The revisions to Chapter 140 of Title 14 of the Virginia Administrative Code entitled "Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act," which amend the rules at 14 VAC 5-140-20, 14 VAC 5-140-30, 14 VAC 5-140-40, 14 VAC 5-140-50, 14 VAC 5-140-60, 14 VAC 5-140-70, 14 VAC 5-140-80, and 14 VAC 5-140-90, and which are attached hereto and made a part hereof, should be, and they are hereby, ADOPTED to be effective July 1, 2002;

(2) AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who forthwith shall give further notice of the adoption of the revisions to the rules by mailing a copy of this Order, together with a clean copy of the revised rules, to all insurers and health services plans licensed to write accident and sickness insurance in the Commonwealth of Virginia; and by forwarding a copy of this Order, including a copy of the attached revised rules, to the Virginia Registrar of Regulations for appropriate publication in the Virginia Register of Regulations; and

(3) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (2) above.

CHAPTER 140.

RULES GOVERNING THE IMPLEMENTATION OF THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS ACT.

14 VAC 5-140-20. ~~Effective date, and other provisions~~ Compliance with chapter.

~~A. This chapter (14 VAC 5-140-10 et seq.) shall be effective on January 1, 1989.~~

~~B.~~ A. No new policy form shall be approved ~~on or after January 1, 1989,~~ unless it complies with this chapter.

~~C.~~ B. No policy form shall be delivered or issued for delivery in this ~~State on or after January 1, 1989,~~ Commonwealth unless it complies with this chapter.

14 VAC 5-140-30. Scope.

This chapter (14 VAC 5-140~~-10 et seq.~~) shall apply to all individual accident and sickness insurance policies delivered or issued for delivery in this Commonwealth except it shall not apply to ~~medicare~~ Medicare supplement, long-term care, and specified disease policies.

Except as otherwise provided, nothing contained in this chapter shall be construed to relieve an insurer of complying with the statutory requirements set forth in Title 38.2 of the Code of Virginia.

14 VAC 5-140-40. Policy definitions.

Except as otherwise provided in this chapter, no individual accident or sickness insurance policy delivered or issued for delivery to any person in this Commonwealth shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

"Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which are the direct result of an accident, independent of disease or bodily infirmity or any other cause, and which occur while the insurance is in force.

Such definition may provide that injuries shall not include:

1. ~~injuries~~ Injuries for which benefits are provided under any ~~workmen's~~ workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law; or

2. ~~injuries~~ Injuries incurred while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

"Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities, and available services.

1. A definition of such home or facility shall not be more restrictive than one requiring that it:

a. Be operated pursuant to law;

b. Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

c. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

d. Provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

e. Maintain a daily medical record of each patient.

2. The definition of such home or facility may provide that such term shall not include:

a. Any home, facility or part thereof used primarily for rest;

b. A home or facility for the aged or for the care of drug addicts or alcoholics; or

c. A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

"Guaranteed renewable" as used in a renewability provision, shall not be defined more restrictively, except as provided in the definition of "non-cancellable" or "non-cancellable and guaranteed renewable," than one providing the insured the right to continue the policy in force by the timely payment of premiums until ~~the~~ age ~~of~~ 65 or until eligibility for Medicare. During this period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by class. Class should be defined by age, sex, occupation, or other broad categories in order to eliminate any possibilities of individual discrimination. Any accident and sickness policy, however, which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age ~~sixty~~ 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

1. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. Be an institution operated pursuant to law;

b. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

c. Provide 24 hours a day nursing service by or under the supervision of a registered graduate professional ~~nurses~~ nurse (~~R.N.'s~~ R.N.).

2. The definition of the term "hospital" may state that such term shall not include:

a. Convalescent homes, convalescent, rest, nursing facilities;

b. Facilities primarily affording custodial, educational or rehabilitory care;

c. Facilities for the aged, drug addicts or alcoholics subject to the requirements of § ~~38.2-3412~~ 38.2-3412.1 of the Code of Virginia; or

d. Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof, except as provided in 14 VAC 5-140-60 E, for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

"Medical necessity," or words of similar meaning, shall not be defined more restrictively than all services rendered to an insured that are required by his medical condition in accordance

with generally accepted principles of good medical practice, which are performed in the least costly setting and not only for the convenience of the patient or his physician.

"Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as ~~"The~~ the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 (42 USC § 1395 et seq.) or "Title I, Part ~~I~~ 1 of the Public Laws 89-97, as ~~Enacted~~ enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the "Health Insurance for the Aged Act," (42 USC § 1395 et seq.), or words of similar import.

"Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind including physiological and psychological dependence on alcohol and drugs subject to § ~~38.2-3412~~ 38.2-3412.1 of the Code of Virginia.

"Non-cancellable," or "non-cancellable and guaranteed renewable," as used in a renewability provision, shall not be defined more restrictively than one providing the insured the right to continue the policy in force by the timely payment of premiums set forth in the policy until ~~the~~ age ~~of~~ 65 or until eligibility for Medicare. During this period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. Any accident and sickness policy, however, which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60, if at age

60, the insured has the right to continue the policy in force at least to age 65 while actively ~~or~~ and regularly employed.

"~~Nurses~~ Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific description as to type, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of this ~~commonwealth~~ Commonwealth.

"One period of confinement" means consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

"Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

"Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician."

"Preexisting condition," except as defined in §§ 38.2-3432.3 and 38.2-3514.1 of the Code of Virginia, shall not be defined to be more restrictive than the following:

1. ~~the~~ The existence of symptoms ~~which~~ that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two ~~(2)~~-year period preceding the effective date of the coverage of the insured person; or

2. ~~a~~ A condition for which medical advice or treatment was recommended by a physician or received from a physician within a two ~~(2)~~-year period preceding the effective date of the coverage of the insured person.

"Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential" duties of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously~~,~~ and totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import ~~which~~ that in the opinion of the ~~Commission~~ commission, adequately and fairly describes the benefit.

"Sickness" shall not be defined to be more restrictive than the following:

Sickness means sickness or disease of an insured person, which manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period, which ~~will~~ shall not exceed 30 days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or

disease for which benefits are provided under any ~~workmen's~~ workers' compensation, occupational disease, employer's liability or similar law.

"Total disability" means:

1. A general description of total disability ~~cannot~~ shall not be more restrictive than one requiring the individual to be totally disabled from engaging in an employment or occupation for which he is or becomes qualified by reason of education, training or experience and not in fact engaged in any employment or occupation for wage or profit.

2. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to: (i) perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or (ii) ~~engaged~~ engage in any training or rehabilitation program.

3. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

14 VAC 5-140-50. General policy requirements.

A. A "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

B. The renewability provisions designated "non-cancellable," "guaranteed renewable" or "non-cancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of 14 VAC 5-140-80 A 1.

C. In a family policy covering both husband and wife, the age of the younger spouse ~~must~~ shall be used as the basis for meeting the age and ~~durational~~ duration requirements of the definitions of "non-cancellable" or "guaranteed renewable." This requirement, however, shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse, to the age or for the ~~durational period as~~ duration specified in ~~said~~ the definition.

D. When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

E. If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written notice of military service, for refund of premiums as applicable to such person on a pro rata basis.

F. In the event the insurer cancels or refuses to renew coverage, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

G. Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

H. Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

I. A policy may contain a provision relating to recurrent disabilities; provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six months.

J. Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability, or occurs within one year from the date of the accident and during a period of continuous total disability resulting from the accident and commencing within 30 days of the date of the accident. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of the accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

K. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

L. Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the

policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

14 VAC 5-140-60. Prohibited policy provisions.

A. Except as provided in the definition of sickness in (14 VAC 5-140-40), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

B. No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six months.

The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

C. No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment, and such preexisting condition is not specifically excluded by the terms of the policy.

D. A disability income protection policy may contain a "return of premium" or "cash value benefit" so long as:

1. Such return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and

2. The insurer demonstrates that the reserve basis for ~~such policies~~ the policy is adequate.

No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

E. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

F. No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

1. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

2. Mental or emotional disorders, alcoholism, and drug addiction, subject to § ~~38.2-3412~~ 38.2-3412.1 of the Code of Virginia;

3. Pregnancy, except for complications of pregnancy, other than for policies defined in 14 VAC 5-140-70 F and G;

4. Illness, treatment or medical condition arising out of:

a. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or ~~units auxiliary thereto~~ auxillary units;

b. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

c. Aviation;

d. With respect to short-term nonrenewable policies, interscholastic sports;

5. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

7. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

8. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal ~~workmen's~~ workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

9. Dental care or treatment;

10. ~~Eye glasses~~ Eyeglasses, hearing aids, and examination for the prescription or fitting thereof;

11. Rest cures, custodial care, transportation, and routine physical examinations;

12. Territorial limitations;

13. Services or care not medically necessary~~.~~ ;

14. Limited benefit health insurance coverage as approved by the commission and in accordance with 14 VAC 5-140-70 H (i).

G. Other provisions of this chapter shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page of the policy.

H. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the ~~Commission~~ commission to disapprove other policy provisions in accordance with § 38.2-3518 of the Code of Virginia ~~which~~ that, in the opinion of the ~~Commission~~ commission, are unjust, unfair, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

I. Except as provided in provisions pertaining to "preexisting conditions" in 14 VAC 5-140-40 ~~F~~, no policy shall exclude coverage for an illness or sickness ~~which~~ that manifests itself ~~(makes itself known)~~ prior to the effective date of the policy.

14 VAC 5-140-70. Accident and sickness minimum standards for benefits.

A. The following minimum standards for benefits are prescribed for the categories of coverage noted in ~~the following~~ subsections B through G of this section. No individual policy of accident and sickness insurance shall be delivered or issued for delivery in this Commonwealth which does not meet the required minimum standards for the specified categories unless the ~~Commission~~ commission finds that ~~such policies~~ the policy or ~~contracts are~~ contract is approvable as ~~Limited Benefit Health Insurance~~ limited benefit health insurance.

Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in §§ 38.2-3519 A and 38.2-3519 B of the Code of Virginia.

B. Basic hospital expense coverage. "Basic hospital expense coverage" is a policy of accident and sickness insurance which provides coverage for a period of not less than 31 days during any continuous hospital confinement for each person insured under the policy, for expenses incurred for the necessary treatment and services rendered as a result of accident or sickness for at least the following:

1. Daily hospital room and board in an amount not less than the lesser of: (i) 80% of the charges for semi-private room accommodations; or (ii) $60 per day;

2. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either: (i) 80% of the charges incurred up to at least $2,000; or (ii) 10 times the daily hospital room and board benefits; and

3. Hospital outpatient services consisting of: (i) hospital services on the day surgery is performed; (ii) hospital services rendered within 72 hours after accidental injury, in an amount not less than $100; and (iii) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent not less than $200 if rendered to an inpatient of the hospital.

4. Benefits provided under subdivisions 1 and 2 ~~or B above,~~ of this subsection may be provided subject to a combined deductible amount not in excess of $200.

C. Basic Medical-Surgical Expense Coverage. "Basic medical-surgical expense coverage" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

1. Surgical services:

a. In amounts not less than those provided on a fee schedule based on the relative values contained in the State of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least $1,000 for any one procedure; or

b. Not less than 80% of the reasonable charges.

2. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with a covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical ~~services~~ service:

a. In an amount not less than 80% of the reasonable charges; or

b. 15% of the surgical service benefit.

3. In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than: (i) 80% of the reasonable charges; or (ii) $10 per day for not less than 31 days during the period of confinement.

D. Hospital confinement indemnity coverage. "Hospital confinement indemnity coverage" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than $30 per day and not less than 31 days during any one period of confinement for each person insured under the policy.

E. Major medical expense coverage. "Major medical expense coverage" is an accident and sickness insurance policy which provides hospital, medical, and surgical expense coverage, to an aggregate maximum of not less than $25,000; copayment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance, in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person for at least:

1. Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than $100 daily (or in lieu thereof, the average daily cost of the semi-private room rate in the area where the insured resides) for a period of not less than 60 days during continuous hospital confinement;

2. Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of not less than $3,000 or 15 times the daily room and board rate if specified in dollar amounts;

3. Surgical services, prior to application of the copayment percentage to a maximum of not less than $1,200 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

4. Anesthesia services, prior to application of the copayment percentage, for a maximum of not less than 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

5. In-hospital medical services, prior to application of the copayment percentage, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required;

6. Out-of-hospital care, prior to application of the copayment percentage, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

7. Not fewer than three of the following additional benefits, prior to application of the copayment percentage, or an aggregate maximum of such covered charges of not less than $2,000:

a. In-hospital private duty ~~graduate registered~~ registered graduate professional nurse services.

b. Convalescent nursing home care.

c. Diagnosis and treatment by a radiologist or physiotherapist.

d. Rental of special medical equipment, as defined by the insurer in the policy.

e. Artificial limbs or eyes, casts, splints, trusses or braces.

f. Out-of-hospital prescription drugs and medications.

g. Treatment for functional nervous disorders, and mental and emotional disorders unless required by § ~~38.2-3412~~ 38.2-3412.1 of the Code of Virginia.

F. Disability income protection coverage. "Disability income protection coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

1. Provides that periodic payments, which are payable after age 62 and reduced solely on the basis of age, are at least 50% of amounts payable immediately prior to age 62.

2. Contains an elimination period no greater than:

a. 90 days in the case of ~~a~~ coverage providing a benefit of one year or less;

b. 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or

c. 365 days in all other cases during the continuance of disability resulting from sickness or injury.

3. Has a maximum period of time for which ~~it~~ a benefit is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage in which case the period for such disability may be limited to one

month. No reduction in benefits shall be put into effect because of an increase in social security or similar benefits during a benefit period.

This section does not apply to those policies providing business ~~buy-out~~ buy-out coverage.

G. Income replacement coverage. "Income replacement coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during which there is a loss of income resulting from sickness, injury, or a combination thereof which:

1. Provides that periodic payments, which are payable after age 62 and reduced solely on the basis of age, are at least 50% of amounts payable immediately prior to age 62.

2. Contains an elimination period no greater than:

a. 90 days in the case of ~~a~~ coverage providing a benefit of one year or less;

b. 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or

c. 365 days in all other cases during the continuance of loss of income resulting from sickness or injury;

3. Has a maximum period of time for which ~~it~~ a benefit is payable during the continuance of loss of income of at least six months except in the case of a policy covering loss of income arising out of pregnancy, childbirth, or miscarriage in which case the maximum period may be limited to one month. No reduction in benefits shall be put into effect because of an increase in social security or similar benefits during a benefit period;

4. Requires loss of income to be no greater than 80% of predisability income in order to pay full periodic benefits; and

5. The front page of the policy shall contain the following statements: THIS IS AN INCOME REPLACEMENT POLICY. THE POLICY PAYS NO BENEFITS IF THERE IS NO LOSS OF INCOME. (This notice must be in capital letters and in no less than 14-point type.)

This section does not apply to those policies providing business ~~buy out~~ buy-out coverage.

H. Limited benefit health insurance coverage. "Limited benefit health insurance coverage" is any policy or contract ~~which provides less coverage than the standards for benefits required under~~ that: (i) provides coverage for a category or categories not specified in subsections ~~B-G~~ B through G of this section~~; or is any policy that~~ , or in any other chapter in Title 14 of the Virginia Administrative Code; (ii) provides coverage for a category or categories specified in subsections B through G of this section, but does not meet the minimum standards for the specified category or categories; or (iii) provides accident only coverage or specified accident only coverage. These policies, ~~if~~ shall be approved by the ~~Commission~~ commission, and upon approval, may be delivered or issued for delivery in this Commonwealth only as ~~Limited~~ limited benefit health insurance and not as ~~basic health expense or indemnity insurance or~~ any other type of coverage defined in this section. These policies ~~must~~ shall meet the disclosure requirements set forth in 14 VAC 5-140-80.

14 VAC 5-140-80. Required disclosure provisions.

A. General rules for all policies.

1. Each individual policy of accident or sickness insurance shall include a renewal, continuation or nonrenewal provision. The language or specifications of such provision ~~must~~

shall be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

2. Except for riders or endorsements by which the insurer fulfills a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After the date of policy issue, any rider or endorsement which increases benefits or coverage with an accompanying increase in premium during the policy term ~~must~~ shall be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

3. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

4. A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include an explanation of such terms.

5. If a policy contains any limitations with respect to preexisting conditions such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting ~~Condition Limitations~~ Conditions Limitation."

6. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the policy.

7. If a policy contains a conversion privilege, it shall comply, in substance, with the following:

a. The caption of the provision shall be "Conversion Privilege," or words of similar import;

b. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised;

c. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage ~~will~~ shall be as provided on a policy form then being used by the insurer for that purpose.

B. Rules for limited benefit policies, other than accident only or specified accident only policies. The following disclosure requirements ~~must~~ shall be met by all limited benefit policies:

1. A cover sheet, containing only the following information shall be permanently attached to the front of the policy:

COMPANY NAME

LOGO (OPTIONAL)

NOTICE: LIMITED BENEFIT DISCLOSURE FORM. THE POLICY DESCRIBED IN THIS COVER SHEET DOES NOT MEET THE MINIMUM STANDARDS REQUIRED BY THE BUREAU OF INSURANCE, VIRGINIA STATE CORPORATION COMMISSION, FOR

INDIVIDUAL ACCIDENT AND SICKNESS POLICIES. (This notice must be in capital letters and in no less than 14-point type.)

Minimum ~~Standards~~ standards were established by the Bureau to insure the availability of health insurance contracts providing a minimum of basic benefits needed for health care. This policy does not meet the Virginia minimum standards for the following reason(s): (A listing of the reason(s) ~~will~~ shall be furnished by the Bureau at the time the contract is reviewed and the actual Bureau language ~~must~~ shall be used.)

(The following language ~~is~~ shall be required for an insurer, other than a direct response insurer.) I have read this cover sheet and realize that this policy does not meet minimum standards required by Virginia law and that it can only be sold as a

LIMITED BENEFIT POLICY.

Signature

FORM NUMBER

This is a disclosure form. It is not part of the policy to which it is attached.

2. The cover sheet shall contain one duplicate copy to be maintained by the insurance company for the length of time that the policy is in force or for three years, whichever is greater.

C. Rules for accident and specified accident only policies. The following disclosure requirement ~~must~~ shall be met by all accident only and specified accident only policies:

Insurers have the option of (i) printing, clearly stamping or printing on gum labels on the first page of the policy, (ii) attaching a cover sheet to the front of the policy or (iii) adding to their outline of coverage, which ~~must~~ shall be attached to the front of the policy, the following information:

NOTICE: THIS IS A LIMITED BENEFIT POLICY. IT DOES NOT PAY ANY BENEFITS FOR LOSS FROM SICKNESS. THIS POLICY PROVIDES RESTRICTIVE COVERAGE FOR CERTAIN LOSSES WHICH OCCUR AS A RESULT OF (AN ACCIDENT) (A SPECIFIED ACCIDENT) ONLY. (This notice ~~must~~ shall be in capital letters and in no less than 14-point type.)

14 VAC 5-140-90. Requirements for replacement.

A. Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection C ~~below~~ of this section. One copy of such notice shall be retained by the applicant, and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in subsection D ~~below~~ of this section. In no event, however, ~~will~~ shall such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

C. The notice required by subsection B ~~above~~ of this section for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (insert Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agency regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

D. The notice required by subsection B ~~above~~ of this section for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (insert Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. (To be included only if the application is attached to the policy.) If, after due consideration you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are

answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert Company Name and Address) within 10 days if any information is not correct and complete, or if any medical history has been left out of the application.

_____

(Company Name)